Eat Right, Happy Life PLLC

Consent for Service, HIPAA, Release, Financials, No-show/Late Cancellation

I, _____, agree to all of the following as outlined below. I will allow Amanda Spies, RDN, to provide nutrition services to me using sound counseling methodologies and science-based practices with the overall goal of helping me to improve my health, eating habits, and/or weight. Nutrition is not an exact science, and no guarantees have been made to me as to the result of interventions.

I understand that Eat Right, Happy Life PLLC will respect my privacy. Amanda may only use or disclose my personal health information for: carrying out treatment, billing insurance, consulting with other healthcare providers and permitted others as annotated below, and for evaluating the quality of services provided and/or any administrative operations related to treatment. I have read the preceding HIPAA Privacy Notice above for Eat Right, Happy Life PLLC.

All fees must be paid in full. Amanda will verify my benefits and bill my insurance company on your behalf. However, I am ultimately responsible for payment of my bill at current hourly rates, listed on the "Services" page available at eatrighthappylife.com.

If I must cancel or change an appointment, I will call/text/email as soon as possible. For an appointment missed or cancelled less than 24 hours in advance, I understand I will owe a $35 fee which is not reimbursed by insurance. This fee will be automatically charged to the card I place on file.

I will pay any co-payment as determined by my insurance at the time of service. After a claim has processed, I agree to pay, promptly and in full, any amounts due to Amanda, including deductibles, co-insurance and amounts due for non-covered services that are not payable by my insurance. I will be contacted about any unexpected costs prior to my card on file being charged.

I give my consent for Amanda to contact the below individuals to request information and provide communication that is directly related to my care.

_____

Healthcare provider name | role (ex: primary care Dr.) | contact information

_____

Healthcare provider name | role (ex: therapist, GI Dr.) | contact information

_____

Family member name | relationship | contact information

_____ _____ _____

Client's Full Name | Client's Signature | Date Signed

___check here if signed by an Authorized Representative Signature (if client is a minor)

Client Contact and Insurance Information

_____ Okay to call? Y / N Okay to leave voicemail? Y / N Okay to text? Y / N

Phone number

_____ Okay to email? Y / N

Email address

If self-pay, stop here. For **insurance**, continue.

_____ _____ _____

Date of Birth Health Insurance Company Contract/Member #

_____

Full home address

_____

Group #

If you are not the policy holder/**subscriber**, please complete.

_____ _____ _____

Subscriber name Subscriber DOB Subscriber Address (if different)

If you have a **secondary insurance plan**, complete this portion.

_____ _____ _____

Health Insurance Company Name Contract/Member # Group #

_____ _____ _____

Subscriber name Subscriber DOB Subscriber Address (if different)

Eat Right, Happy Life
Credit/Debit Card Authorization Form

Your card will only be charged in the situations described below- most clients using insurance are never charged. You may cancel this authorization at any time by contacting me at amandaspies321@gmail.com or faxing to 334-339-6342. This authorization will remain in effect until cancelled or until services are terminated and all fees settled.

Credit/Debit Card Information
Cardholder Name (as shown on card): _____
Card Number: _____
Card Security Code:__ __ __
Expiration Date (mm/yy):__ __ / __ __
ZIP Code (from billing address): _____

Being the authorized cardholder, I _____, understand and agree to the terms set forth in the aforementioned cancellation policy, agree to pay, and specifically authorize to charge my credit/debit card as set out below. By signing this form, I authorize Amanda Spies of Eat Right, Happy Life PLLC to charge my card for insurance co-pays, co-insurance, other services not covered by insurance, less than 24-hour cancellations, appointment no-shows, and/or self-pay session fees. I further agree that in the event my credit card becomes invalid, I will provide a new valid credit card upon request. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Client Signature Date

_____

Client Name

***Step 2: Fax (334-339-6342) or email (amandaspies321@gmail.com) completed form AND pictures of ID and insurance card.

Step 3: Contact your doctor to tell them you will be working with a Registered Dietitian. If desired/required, request they fax me (334-339-6342) your medical info. Thank you!***